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In this issue

SNOMED is coming, and more about using and interacting with technology in primary care

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What is always coming but never arrives?

The usual answer is 'Tomorrow' – but maybe in informatics it should be SNOMED. This issue's editorial reflects on SNOMED CT, the allure of a comprehensive terminology with linkable terms. However, is SNOMED ready for us and are we ready for SNOMED? The Editorial says more...[1]

The paper by Mabotuwana *et al* illustrates that there is a gap between prescribing and dispensing of antidepressant medications.[2] Poor adherence identified through prescribing data is nearly always correct; however, poor prescribing data only predicts around half of those who have poor adherence at the dispensing stage. Therefore, monitoring of prescribing adherence is important but this won't identify all the problems. Although this study was carried out in the context of antidepressant prescribing, it concurs with my own research in the area of osteoporosis where compliance with bisphosphonates was problematic.[3] There is of course a third level to adherence, where patients have their medication dispensed and with the experiential learning many primary care physicians have on home visits of finding one or more items of a patient's prescription stock piled in the cupboard.

The paper on adherence is followed by two papers about electronic communications. The first, by Hanna *et al,* looks at practice managers' attitudes and reports how managers may perceive the lack of current use of electronic communication as a lack of demand.[4] The role of managers as a facilitator or barrier to the use of IT has been little studied and this paper provides valuable insights and builds on previous work suggesting an emergent independence of this professional group.[5–7] The second, from Karhula *et al,* looks at the different ways email is used in primary care.[8] Whilst some findings are less surprising for example: it is hard to make complex decisions by email, some are not read, and how the leaders in primary care prefer this as a medium – others findings are more surprising. For example, those in rural areas use less email than their urban colleagues.

Ellis and Herbert continue to describe how we should think of ourselves as working in a complex adaptive system (CAS).[9] CAS provide a framework for sensemaking.[10] Sensemaking as described by Weick is a set of ideas with explanatory possibilities. He described it as an ongoing conversation rather than a rigid body of knowledge. In this paper the authors describe how study participants were more likely to successfully implement clinical governance objectives when supported by informatics.

Benavides *et al* report how generic information support for prescribing is more useful in prescribing in children than specific paediatric tools.[11] Finally come two short reports – Honekamp and Ostermann describe their FITT framework for modelling IT.[12] This model of needing to look at the fit of the individual, the technology and the task is remarkably similar to conceptual frameworks in informatics arrived at by your editor who proposed the same three items adding 'organisation' as a fourth. However, this work was in the context of identifying the barriers to clinical coding.[13] The last paper in this issue is an exploratory study of the use of computerised note keeping in an audiology clinic. This exploratory study describes the acceptability of computer use in an audiology clinic.[14]

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